GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

Administrative Issuance: CFSA-06-20

TO: All CFSA Staff

FROM: Dr. Roque Gerald, Deputy Director for Clinical Practice

DATE: November 1, 2006

RE: Protocol for Referring Clients to Substance Abuse Treatment

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Substance abuse is just one of multiple challenges confronting youth and families served by the Child and Family Services Agency (CFSA). As a maladaptive coping mechanism for individuals who have been traumatized, like many foster youth and birth parents, substance abuse seriously aggravates the barriers to self-sufficiency and wellness. Therefore, it is incumbent upon social workers to assess a client's need for substance abuse treatment as part of any initial investigation and throughout the life of an ongoing case.

This administrative issuance outlines the requirements and procedures that CFSA staff must follow when referring clients for substance abuse treatment. This issuance replaces the CFSA Substance Abuse policy. If you have any questions regarding this issuance, please contact the Multidisciplinary Unit Supervisor and/or the Clinical Support Services Administrator.

There are currently three (3) Substance Abuse Specialists (SAS) in the Agency who provide clinical support and consultation for staff when parental and/or adolescent substance abuse is suspected or confirmed during the course of an investigation of alleged child maltreatment or throughout the life of an ongoing case. The two (2) Intake Substance Abuse Specialists (ISAS) provide clinical support and consultation on child protective services (CPS) investigations while the OCP Substance Abuse Specialist (OCP SAS) provides clinical support and consultation for ongoing cases.

General Referral Process

1. Social workers shall complete the relevant referral form (see Attachments A-C).

2. Social workers must complete the attached Authorization to Disclose Mental Health or Substance Abuse Information form in its entirety (See Attachment D). This form allows the social worker to receive necessary but confidential information from the required Addiction Prevention and Recovery Administration (APRA) intake assessment.

3. Social workers shall take the assessment recommendations of the substance abuse specialist(s) into consideration as part of overall case planning and identification of needed services for the client. If the recommendation for treatment appears to conflict with elements of the case plan or with the client's current state of affairs, it may be necessary for the social worker to identify alternate client options post-assessment.

Referrals from CPS social workers

1. The referring CPS social worker shall complete and submit the required documentation including the social summary, mental evaluations, court orders, and court report, as applicable, for a substance abuse assessment to the Intake Substance Abuse Specialists (ISAS).

2. The assigned ISAS shall schedule a substance abuse assessment to be completed at CFSA or in the community.

3. The ISAS shall complete the assessment and recommend a level of care to the CPS social worker and client within 2-24 hours of receipt of the initial referral. If there is an emergent need for services after hours, the CPS social worker is instructed to take the client directly to Detox at DC General Hospital, Building 12, for an assessment.

4. Within 2-24 hours after the assessment, if Detox is needed, ISAS shall contact APRA's Assessment and Referral Center (ARC) and forward the client's referral documentation, including related findings and recommendations for follow-up. Clients are not required to have an appointment before a referral is submitted for the intensive out-patient programs. ISAS shall notify the CPS social worker when the relevant client documentation has been sent to APRA to complete the assessment.

5. APRA's ARC is responsible for completion of client financial and medical assessments. This is the final step before substance abuse treatment services can be initiated.

6. The CPS social worker is responsible for documenting all contacts in FACES, including referral information.

Referrals from on-going social workers

1. The referring on-going social worker shall complete and submit the required documentation including the social summary, mental evaluations, court orders, and court report, as applicable, for a substance abuse assessment to the OCP Substance Abuse Specialist (OCP SAS).

2. In addition, on-going social workers shall attach a brief social summary to the referral, including the following information:
    a. client background information (neglect or abuse);
    b. prior treatment history, including modality;
    c. mental health diagnosis;
    d. current prescriptions; and
    e. medical history (where available).

3. The substance abuse assessment shall be completed by either the OCP SAS at CFSA or by APRA. The location of the assessment is based on the time and resource needs of the client and social worker (e.g. child care, transportation, etc.)

4. If the assessment is completed at CFSA, the OCP SAS shall attempt to place the client in a program based on the identified level of need and/or refer the case to APRA.

5. The OCP SAS shall review the referral package for completeness and appropriateness prior to submission to APRA for an intake assessment appointment.

6. The OCP SAS shall provide appointment information to the on-going social worker via email and/or a telephone call within three (3) business days of the initial referral. Emergency referrals will be handled on a case-by-case basis.

7. The on-going social worker shall notify the client of the date and time of the appointment within one (1) business day and also provide the client with the telephone number of the Assessment and Referral Center (202-727-8609). The on-going social worker or designee shall provide support by accompanying the client to the appointment.

8. Substance abuse assessments for youth (up to 21 years of age) occur at the APRA Youth Central Intake Division located at 3720 Martin Luther King Jr. Ave., SE, 2nd Floor and the assessments for adults (21 years and older) occur at the APRA Adult Central Intake Division located at 1300 First Street, NE, 2nd Floor.

9. Clients must have a valid [photograph] ID to receive services.

10. If necessary, bus tokens shall be provided by the social worker for the client's round-trip transportation to the ARC. Tokens and fare cards can be obtained from the secretary of the on-going social worker's Program Manager.

11. The OCP SAS tracks the case with follow-up calls to APRA. The on-going social worker may need to contact the OCP SAS for the following reasons:
    a. if there are any concerns;
    b. other assistance is needed with the appointment; or
    c. verification of appointments, kept or missed, is needed.

12. The on-going social worker is responsible for documenting substance abuse treatment goals and activities in the case plan; all contacts must be entered in FACES.

CHILD AND FAMILY SERVICES AGENCY
Office of Clinical Practice
Intake Substance Abuse Service Referral Form

Date of Request: ____/____/_____ CPS Worker's Name: _____
Telephone # _____ Email Address:_____
Room #_____
Is this substance abuse services referral court ordered? ☐ Yes ☐ No
Is this referral the result of a FTM? ☐ Yes ☐ No

For Adult Use Only (ages 21 and over):

Client Name: _____ ☐ Female ☐ Male
DOB: ____/____/_____ Social Security #:_____
CPS Referral Number#_____
Health Insurance provider and #:_____
Client Address: _____
Telephone Number: _____Alt. Number: _____
Number of Children: _____ Ages: _____
Employed?: ☐ Yes ☐ No
Name of Employer: _____

If a "parent w/child" slot is available, can child (ren) enter TX w/the mother? ☐ Yes ☐ No
(Please be advised that most treatment programs of this type have a "cap" on the age and number of children that can reside in the program with their mother)

Client uses the following: ☐ Marijuana ☐ Cocaine ☐ Alcohol ☐ Heroin ☐ PCP ☐ Ecstasy
☐ Other (please specify): _____
Client has a history of the following:
Substance Abuse Treatment? ☐ Yes ☐ No
Legal Problems? ☐ Yes ☐ No
Medical Problems? ☐ Yes ☐ No

For Adolescents Only (ages 20 and younger):

Client Name: _____ ☐ Female ☐ Male
DOB: ____/____/_____ Social Security #:_____
CPS Referral Number#_____
Health Insurance provider and #:_____
Client Address: _____
Telephone Number: _____
Legal status: ☐ Administrative Hold ☐ Shelter Care ☐ Committed
Custodial Parent/Legal Guardian Name: _____
Custodial Parent/Legal Guardian Address: _____
_____
Client address if different from above: _____
_____
School: _____ Last grade completed: _____
Is client in special education program? ☐ Yes ☐ No
Client uses the following: ☐ Marijuana ☐ Cocaine ☐ Alcohol ☐ Heroin ☐ PCP ☐ Ecstasy
☐ Other (please specify): _____
Client has a history of the following:
Substance Abuse Treatment? ☐ Yes ☐ No
Legal Problems? ☐ Yes ☐ No
Medical Problems? ☐ Yes ☐ No

Per client please include: A copy of the court order (if applicable) and a bio-psychosocial summary. An Authorization to Disclose Mental Health or Substance Abuse Information MUST BE SIGNED

400 Sixth Street, SW ♦ Washington, DC 20024
Web: www.cfsa.dc.gov

Child and Family Services Agency
400 6th Street, S.W.
Washington, D.C. 20024
Adolescent Substance Abuse Referral Form

Date of Referral:_____

Social Worker Name: _____

Program Area: ☐ CPS ☐ In-Home ☐ Adoptions

Telephone #:_____

Room #:_____

Client Name: _____ DOB: _____

Social Security #:_____ Medicaid#:_____

Telephone #: _____ FACES ID #:_____

Is this referral the result of a FTM? ☐ No ☐ Yes Date: _____ Facilitator Name:_____

Is the client a Committed Ward of the District of Columbia? ☐ Yes ☐ No

Custodial Parent/Legal Guardian Name: _____

Custodial Parent/Legal Guardian Address: _____

_____

Client address if different from above: _____

_____

Client School: _____ Last grade completed: _____

Is client in special education program? ☐ Yes ☐ No

Client uses the following: ☐ Marijuana ☐ PCP ☐ Ecstasy ☐ Cocaine ☐ Alcohol

Other (Please specify):_____

Does the client have a DSM IV diagnosis? ☐ Yes ☐ No

If yes please identify diagnosis and medication: _____

_____

Name of current Psychiatrist/Therapist: _____

Psychiatrist/Therapist Telephone #:_____

PLEASE DO NOT WRITE BELOW THIS LINE

Client referred to:

Program Name: _____

Program Location: _____

Telephone Number: _____ Contact Person: _____

Appt Date & Time: _____

Please return this form to Richard Davis, CAC RAC Substance Abuse Specialist (202)727-2409 Cubicle # 4008

Please include: Copy of court order (if ordered), Social Summary (include drug use and treatment history), along with any psychiatric or psychological evaluations that may have been done recently (no more than 1 year old). An Authorization to Disclose Mental Health or Substance Abuse Information MUST BE SIGNED

CHILD AND FAMILY SERVICES AGENCY
400 6th Street, S.W.
Washington, D.C. 20024
Adult Substance Abuse Referral Form

Date of Referral:_____
Social Worker Name:_____
Program Area: ☐ CPS ☐ In-Home ☐ Adoptions
Telephone #: _____
Room #:_____
Referral by way of:
☐ In Person ☐ Fax ☐ E-Mail

Is this referral court ordered? ☐ Yes ☐ No
Is this referral the result of a FTM? ☐ No ☐ Yes Date: _____ Facilitator: _____

Client Name: _____
☐ Female ☐ Male DOB: _____ FACES ID:_____
Social Security #:_____ Medicaid #_____
Client Address: _____
Telephone Number: _____ Alternate Number: _____
Number of Children: _____ Ages: _____

If a parent w/child slot is available can child (ren) enter TX w/the mother? ☐ yes ☐ no
(Please be advised that most treatment programs of this type have a "cap" on the age and number of children that can reside in the program with their mother)

Client uses the following: ☐ Marijuana ☐ Cocaine ☐ Alcohol ☐ Heroin ☐ PCP ☐ Ecstasy
☐ Other (please specify): _____

FOR APRA USE ONLY:

Date client reported for initial screening/assessment: _____
☐ **Client has agreed to accept services**
☐ **Client has declined services**

Reason for non-compliance:_____

Client has been referred for the following treatment program:
☐ **Detoxification** ☐ **Inpatient** ☐ **Outpatient** ☐ **Intensive outpatient** ☐ **Aftercare**

Program Name: _____
Program Address: _____
Length of Services: _____
Telephone Number: _____ Contact Person: _____

Please return this form to Richard Davis, CAC RAC Substance Abuse Specialist (202)727-2409 Cubicle # 4008

Please include: Copy of court order (if ordered), Social Summary (include drug use and treatment history), along with any psychiatric or psychological evaluations that may have been done recently (no more than 1 year old). An Authorization to Disclose Mental Health or Substance Abuse Information MUST BE SIGNED

400 Sixth Street, SW ♦ Washington, DC 20024
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GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

Authorization to Disclose Mental Health or Substance Abuse Information

***Si usted no entiende el idioma Inglés, favor de pedir este formulario en Español**.*

Instructions

- Use this Authorization to authorize CFSA to disclose mental information or substance abuse information about a client (adult or child). Also use this Authorization to disclose mental health information or substance abuse information to CFSA.

- Do not use this Authorization for the release of health information that is not mental health or substance abuse information. Instead, use the "Authorization to Disclose Medical or Dental Information".

- If the client or personal representative is Spanish-speaking and does not read English, give her or him the Spanish version of this Authorization.

- If a client is physically unable to complete the Authorization, CFSA staff may complete the Authorization under the direction of the client, or her or his personal representative, as long as the client, or her or his personal representative, signs or marks the Authorization.

- This Authorization must be signed by someone who legally can make decisions regarding the health care of the individual who is the subject of the health information. This is generally the individual if he or she is 18 years of age or older and, except as provided below, generally the parent or legal guardian if the individual is under 18 years of age. For mental health information, if the individual is between 14 and 18 years of age, the child *and* the parent or legal guardian must sign the consent *unless* the child received the mental health treatment without the parent/legal guardian's consent; in that circumstance, if CFSA is seeking the disclosure of information concerning the services or supports received, the child *alone* is the person who must sign the Authorization. If the parent or legal guardian is not available to sign, or there are questions about who can sign, contact Health Services or the Office of General Counsel for directions on how to proceed.

- Use a separate Authorization for each disclosure of information to CFSA or by CFSA.

400 Sixth Street, SW ♦ Washington, DC 20024
Web: www.dcchildandfamilyservices.com

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

Authorization to Disclose Mental Health or Substance Abuse Information

***Si usted no entiende el idioma Inglés, favor de pedir esta forma en Español**.*

See instructions on cover page

Section A: Individual who is the subject of the information		
Last Name:	First Name:	Middle Initial:
Any other name used:		
Address: *(Street Address/City/ State/Zip)*		
Telephone:		
Date of Birth: (*Month/Day/Year)*	Social Security Number:	

Section B: Authorized use or disclosure

I, _____ , authorize _____

(individual or personal representative) *(person/organization authorized to disclose information)*

_____

to disclose the following information concerning the above-identified person to: _____

_____ .

(person/organization authorized to receive information)

Information Authorized to be Released *(Check all that apply and provide additional information as needed):*

☐ Mental Health (*Describe*):

☐ Substance Abuse (*Describe*):

400 Sixth Street, SW ♦ Washington, DC 20024
Web: www.dcchildandfamilyservices.com

☐ In authorizing this disclosure, I understand that this information will be used for the purpose of:

_____

_____

_____

_____

_____

- I understand that this Authorization permits the release of both oral information and documents.
- I understand that the client has the right to inspect her or his record of mental health information.
- I understand that I may revoke this Authorization at any time by giving my written revocation to:

D.C. Child and Family Services Agency
Attention: CFSA Privacy Office
400 6th Street S.W.
Washington, DC 20024

- I understand that revocation of this Authorization will *not* affect any action CFSA took in reliance of this authorization before it received written notice of my revocation.
- I understand that this Authorization will expire sixty (60) days from the date on which I sign it, and that I may sign a new authorization for an additional sixty (60) days. The authorization will expire on _____.
- I have received a copy of this Authorization.
- **I understand that this Authorization is voluntary and that CFSA will not condition any treatment that would otherwise be provided on this Authorization.**

Section C: Signature

Signature:	If this authorization is signed by a personal representative on behalf of the individual, complete the following:
Print Name (*Last/First/Middle Name*):	Personal Representative's Name:
Address:	Relationship to Individual *(check one):* ☐ Parent ☐ Legal guardian ☐ Legal Custodian
Phone number:	
Date:	

THIS AUTHORIZATION EXPIRES 60 DAYS FROM THE APPROVAL DATE.

Include this Authorization in the individual's records and provide a copy to the individual or her/his personal representative.

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Web: www.dcchildandfamilyservices.com